Solicitation Information
March 18, 2016

RFP# 7550421

TITLE: Independent Audit Services – Disproportionate Share of Hospital Claims

Submission Deadline: April 15, 2016 at 10:00 AM (Eastern Time)

PRE-BID/ PROPOSAL CONFERENCE: No
MANDATORY:
If YES, any Vendor who intends to submit a bid proposal in response to this solicitation must have its designated representative attend the mandatory Pre-Bid/ Proposal Conference. The representative must register at the Pre-Bid/ Proposal Conference and disclose the identity of the vendor whom he/she represents. A vendor's failure to attend and register at the mandatory Pre-Bid/ Proposal Conference shall result in disqualification of the vendor's bid proposals as non-responsive to the solicitation.

DATE:
LOCATION:

Questions concerning this solicitation must be received by the Division of Purchases at david.francis@purchasing.ri.gov no later than **March 29, 2016 at 10:00 AM (ET).** Questions should be submitted in a *Microsoft Word attachment.* Please reference the RFP# on all correspondence. Questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

SURETY REQUIRED: No

BOND REQUIRED: No

David J. Francis
Interdepartmental Project Manager

Applicants must register on-line at the State Purchasing Website at www.purchasing.ri.gov

Note to Applicants:

Offers received without the entire completed three-page RIVIP Generated Bidder Certification Form attached may result in disqualification.

THIS PAGE IS NOT A BIDDER CERTIFICATION FORM

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SECTION 1: INTRODUCTION

The Rhode Island Department of Administration/Division of Purchases, on behalf of the Executive Office of Health and Human Services (EOHHS), the State Medicaid Agency, is soliciting proposals from independent CPA firms to perform independent certified audits of Disproportionate Share Hospital (DSH) claims, in accordance with the terms of this Request for Proposals and the State's General Conditions of Purchase, which may be obtained at the Rhode Island Division of Purchases Home Page by Internet at www.purchasing.ri.gov .

The initial contract period will begin approximately May 2016 for three (3) years. Contracts may be renewed for up to three (3) additional 12-month periods based on vendor performance and the availability of funds.

This is a Request for Proposals, not an Invitation for Bid. Responses will be evaluated on the basis of the relative merits of the proposal, in addition to price; there will be no public opening and reading of responses received by the Division of Purchases pursuant to this Request, other than to name those offerors who have submitted proposals.

INSTRUCTIONS AND NOTIFICATIONS TO OFFERORS:

1. Potential vendors are advised to review all sections of this RFP carefully and to follow instructions completely, as failure to make a complete submission as described elsewhere herein may result in rejection of the proposal.

2. Alternative approaches and/or methodologies to accomplish the desired or intended results of this procurement are solicited. However, proposals which depart from or materially alter the terms, requirements, or scope of work defined by this RFP will be rejected as being non-responsive.

3. All costs associated with developing or submitting a proposal in response to this RFP, or to provide oral or written clarification of its content shall be borne by the vendor. The State assumes no responsibility for these costs.

4. Proposals are considered to be irrevocable for a period of not less than 60 days following the opening date, and may not be withdrawn, except with the express written permission of the State Purchasing Agent.

5. All pricing submitted will be considered to be firm and fixed unless otherwise indicated herein.

6. Proposals misdirected to other state locations, or which are otherwise not present in the Division at the time of opening for any cause will be determined to be late and will not be considered. For the purposes of this requirement, the official time and date shall be that of the time clock in the reception area of the Division.

7. It is intended that an award pursuant to this RFP will be made to a prime vendor, or prime vendors in the various categories, who will assume responsibility for all aspects of the work. Joint venture and cooperative proposals will not be considered. Subcontracts are permitted, provided that their use is clearly indicated in the vendor's proposal and the subcontractor(s) to be used is identified in the proposal.

8. All proposals should include the vendor's FEIN or Social Security number as evidenced by a W9, downloadable from the Division's website at www.purchasing.ri.gov.

9. The purchase of services under an award made pursuant to this RFP will be contingent on the availability of funds.

10. Vendors are advised that all materials submitted to the State for consideration in response to this RFP will be considered to be Public Records as defined in Title 38, Chapter 2 of the General Laws of Rhode Island, without exception, and will be released for inspection immediately upon request once an award has been made.

11. Interested parties are instructed to peruse the Division of Purchases website on a regular basis, as additional information relating to this solicitation may be released in the form of an addendum to this RFP.

12. Equal Employment Opportunity (G.L. 1956 § 28-5.1-1, et seq.) – § 28-5.1-1 Declaration of policy – (a) Equal opportunity and affirmative action toward its achievement is the policy of all units of Rhode Island state government, including all public and quasi-public agencies, commissions, boards and authorities, and in the classified, unclassified, and non-classified services of state employment. This policy applies to all areas where State dollars are spent, in employment, public services, grants and financial assistance, and in state licensing and regulation.

13. In accordance with Title 7, Chapter 1.2 of the General Laws of Rhode Island, no foreign corporation, a corporation without a Rhode Island business address, shall have the right to transact business in the State until it shall have procured a Certificate of Authority to do so from the Rhode Island Secretary of State (401-222-3040). This is a requirement only of the successful vendor(s).

14. The vendor should be aware of the State's Minority Business Enterprise (MBE) requirements, which address the State's goal of ten percent (10%) participation by MBE's in all State procurements. For further information visit the website www.mbe.ri.gov

15. Under HIPAA, a "business associate" is a person or entity, other than a member of the workforce of a HIPAA covered entity, who performs functions or activities on behalf of, or provides certain services to, a HIPAA covered entity that involves access by the business associate to HIPAA protected health information. A "business associate" also is a subcontractor that creates, receives, maintains, or transmits HIPAA protected health information on behalf of another business associate. The HIPAA rules generally require that HIPAA covered entities and business associates enter into contracts with their business associates to ensure that the business associates will appropriately safeguard HIPAA protected health information. Therefore, if a Contractor qualifies as a business associate, it will be required to sign a HIPAA business associate agreement

16. In order to perform the contemplated services related to the Rhode Island Health Benefits Exchange (HealthSourceRI) , the vendor hereby certifies that it is an "eligible entity," as defined by 45 C.F.R. § 155.110, in order to carry out one or more of the responsibilities of a health insurance exchange. The vendor agrees to indemnify and hold the State of Rhode Island harmless for all expenses that are deemed to be unallowable by the Federal government because it is determined that the vendor is not an "eligible entity," as defined by 45 C.F.R. § 155.110.

SECTION 2: BACKGROUND

Title XIX of the Social Security Act (Act) authorizes Federal grants to States for Medicaid programs that provide medical assistance to low-income families, the elderly, and persons with disabilities. Section 1902(1)(13)(A)(iv) of the Act requires that States make Medicaid payment adjustments for hospitals that serve a disproportionate share of low-income patients with special needs. Section 1923 of the Act contains more specific requirements related to such disproportionate share hospital (DSH) payments, including aggregate annual state-specific limits on Federal financial participation under Section 1923(f), and hospital-specific limits on DSH payments under Section 1923(g). Under those hospital specific limits, a hospital's DSH payments may not exceed the costs incurred by that hospital in furnishing services during the year to Medicaid patients and the uninsured, less other Medicaid payments made to the hospital, and payments made by the uninsured patients ("uncompensated care costs"). In addition, Section 1923(a)(2)(D) requires States to provide an annual report to the Secretary describing the payment adjustments made to each disproportionate share hospital. Section 1923(j)(1) of the Act requires States to submit an annual report, Section 1923(j)(2) of the Act requires States to have their DSH payment programs independently audited and to submit the independent certified audit annually to the Secretary and Section 1923(j) of the Act also makes Federal matching payments contingent upon a State's submission of the annual DSH report and independent certified audit.

PURPOSE:

EOHHS, the State Medicaid Agency, is soliciting proposals to contract an independent CPA firm to perform Disproportionate Share Hospital (DSH) audits. The contract will be for a base term of five years with two (2) optional renewal years.

The first year of the contract resulting from this RFP will be an audit of the Medicaid State Plan (MSP) year 2013, with each subsequent contract year corresponding with each subsequent MSP year. The contractor must review the criteria of the Federal audit regulation and complete the verification, calculations and report under the professional rules and generally accepted standards of audit practice. Certification of the audit would include a review of the State's audit protocol to ensure that the Federal regulation is satisfied, an opinion for each verification detailed in the regulation, and a determination of whether or not the State made DSH payments that exceeded a hospital's specific DSH limit in the Medicaid State plan year under audit. The certification should also identify any data issues or other caveats that the contractor identifies as impacting the results of the audit. **Attachment B** contains a list of the hospitals to be audited.

ATTACHMENTS:

A. Cost Form
B. Disproportionate Share Hospitals
C. General DSH Audit and Reporting Protocol
D. Additional Information on the DSH Reporting and Audit Requirements

SECTION 3: SCOPE OF WORK

General Scope of Work

EOHHS is soliciting proposals to contract an independent CPA firm to perform Disproportionate Share Hospital (DSH) audits. The contractor will determine whether a desk and/or on-site audit is required. The first year of the contract resulting from this RFP will be an audit of the Medicaid State Plan (MSP) year

2013, with each subsequent contract year corresponding with each subsequent MSP year. The contractor must review the criteria of the Federal audit regulation and complete the verification, calculations and report under the professional rules and generally accepted standards of audit practice. Certification of the audit would include a review of the State's audit protocol to ensure that the Federal regulation is satisfied, an opinion for each verification detailed in the regulation, and a determination of whether or not the State made DSH payments that exceeded a hospital's specific DSH limit in the Medicaid State plan year under audit. The certification should also identify any data issues or other caveats that the contractor identifies as impacting the results of the audit.

Section 1923(j)(2) of the Social Security Act requires States to have their DSH payment programs independently audited and to submit the independent certified audit annually to the Secretary. The certified independent audit must verify:

- The extent to which a hospital has reduced uncompensated care costs to reflect the total amount of claimed expenditures made under Section 1923 of the Act.
- DSH payments to each hospital comply with its applicable DSH payment limit.
- Only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and uninsured individuals as described in Section 1923(g)(1)(A) of the Act are included in the calculation of the hospital-specific limits.
- The State included all Medicaid payments, including supplemental payments, in the calculation of such hospital specific limits.
- The audits conducted under the resulting contract must meet the requirements of 42 CFR parts 447 and 445, Final Rule, 73 FR 77904, December 19, 2008, and any amendments. CMS has developed a General DSH Audit and Reporting Protocol (Attachment C) which the contractor will use in order to comply with this rule.

The DSH audit will rely on existing cost reporting tools and documents as primary sources for the data necessary to evaluate DSH payments against hospital specific DSH costs. Two of the primary source documents are the Medicare 2552-10 hospital cost report and audited hospital financial statements (and other auditable hospital accounting records).

It will be the responsibility of all Rhode Island Hospitals, including Eleanor Slater Hospital, receiving DSH payments from the State of Rhode Island to make available to the auditors all audited hospital financial statements (and other auditable hospital accounting records) and audited and unaudited Medicare cost reports, including all work papers, for the DSH Plan year's covered by this Request for Proposal.

Specific Activities / Tasks

To be considered responsive to this RFP, offerors must possess and demonstrate within their proposal the following minimum requirements. An offeror's failure to meet these minimum prior experience requirements will cause their proposal to be considered non-responsive and their proposal will be rejected.

The contractor must retain persons with expertise and recent professional practice per the following minimum requirements:

1. The Audit Manager must be a CPA and have a minimum of five (5) years of experience with generally accepted accounting principles and financial auditing standards with specific expertise in the area of State and Federal Medicaid, Medicare, and DSH policies, regulations and statutes, as well as experience performing DSH audits. The experience requirements must be met through specific

experience with United States principles and standards. The five years' experience must have occurred within the last seven years.

2. All staff assigned to the project, including subcontractors, must have a minimum of one (1) year of experience with generally accepted accounting principles and financial statement auditing standards with specific expertise in the area of state and Federal Medicaid, Medicare and DSH policies, regulations and statutes. The experience requirements must be met through specific experience with United States principles and standards. The one year of experience must have occurred within the last five years.
3. If subcontractors are used, of the assigned staff, a minimum of 50%, including management positions employed by the contractor, must be direct employees of the prime contractor.

The Audit Report for Year 1 of the Contract (MSP year 2013) must be complete by a date that allows the State to complete and submit its report to CMS not later than December 31, 2016, with a draft of same report to be submitted to EOHHS no later than 9/30/16. These month end dates apply, respectively, to all subsequent years' reports.

General Audit Responsibility:

It is the contractor's responsibility to:

- Review State's methodology for estimating hospital's OBRA 1993 hospital-specific DSH limit and the State's DSH payment methodologies in the approved Medicaid State plan for the State plan rate year under audit.
- Review state's DSH audit protocol to ensure consistency with IP/OP Medicaid reimbursable services in the approved Medicaid State plan. Review DSH audit protocol to ensure that only costs eligible for DSH payments are included in the development of the hospital specific DSH limit.
- Compile hospital specific IP/OP cost report data and IP/OP revenue data to measure a hospital's DSH limit in auditable year. In determining this limit, the auditor must measure both components of the hospital specific DSH limit. To determine the existence of a Medicaid shortfall, Medicaid IP/OP hospital costs (including Medicaid managed care costs) must be measured against Medicaid IP/OP revenue received for such services in the audited State Plan rate year (including regular Medicaid rate payments, add-ons, supplemental and enhanced payments and Medicaid managed care revenues). Costs associated with patients with no source of third party coverage must be reduced by applicable revenues and added to any Medicaid shortfall to determine total eligible DSH costs.
- Compile total DSH payments made in auditable year to a hospital (including DSH payments received by the hospital from other States).
- Compare hospital specific DSH costs limits against hospital specific total DSH payments in the audited Medicaid State plan rate year. Summarize findings identifying any overpayments/underpayments to particular hospitals.

Independent Certified Audit:

The independent certified audit must verify the following:

- Verification 1: A hospital is allowed to retain that payment so that the payment is available to offset its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the Medicaid State plan year to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures.
- Verification 2: DSH payments made to a hospital comply with the hospital-specific DSH payment limit. For each audited Medicaid State plan rate year, the DSH payments made in that audited

Medicaid State plan rate year must be measured against the actual uncompensated care cost in that same audited Medicaid State plan year.

- Verification 3: Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no third party coverage for the inpatient and outpatient hospital services they received as described in Section 1923(g)(1)(A) of the Act are eligible for inclusion in the calculation of the hospital-specific disproportionate share limit payment limit, as described in Section 1923(g)(1)(A) of the Act.
- Verification 4: For purposes of this hospital-specific limit calculation, any Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to a disproportionate share hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals, which are in excess of the Medicaid eligible individuals, which are in excess of the Medicaid incurred costs of such services, are applied against the uncompensated care costs of such services, are applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for such services.
- Verification 5: Any information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments; and any payments made on behalf of the uninsured from payment adjustments has been separately documented and retained by the State.
- Verification 6: The information specified in Verification 5 includes a description of the methodology for calculating a hospital's payment limit under Section 1923(g)(1) of the act. Included in the description of the methodology, the audit report must specify how the each hospital defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they received.

Specific Areas of Review:

1. MMIS Data
- State MMIS generated IP hospital payments, ancillary charges and routine days for the cost reporting period(s) covering the Medicaid State plan rate year under audit for each DSH hospital.
- State MMIS generated OP hospital payments and ancillary charges for the cost reporting period(s) covering the Medicaid State plan rate year under audit for each DSH hospital.

2. Approved Medicaid State Plan
- DSH hospital determination criteria and data used to determine eligibility for the Medicaid State plan rate year under audit.
- Medicaid State Plan DSH payment methodologies for the Medicaid State plan rate year under audit.
- State DSH payments to each hospital for the Medicaid State plan rate year under audit.
- State methodology for determining the hospital-specific DSH limit, the data used to determine such limit and the hospital-specific cost limit generated by methodology and data for the Medicaid State plan rate year under audit.

3. Medicare 2552-96 Hospital Cost Report
- Medicare 2552-96 hospital cost report(s) for the Medicaid State plan rate year under audit (finalized when available or as filed).

4. Audited Hospital Financial Statements and Other Auditable Hospital Accounting Records
- Hospital revenues from Medicaid managed care organizations, Medicaid payments from other States (regular payments including add-ons, supplemental and enhanced payments, DSH payments), and

Medicaid IP/OP hospital payments from all sources other than the State from hospital financial reports and records for the cost reporting period(s) covering the Medicaid State plan rate year under audit.

- Hospital revenues from or on behalf of with no source of third party coverage for the hospital services provided.
- Days and charges for IP/OP Medicaid hospital services for services provided to out of state Medicaid patients.
- Days and charges for IP/OP hospital services provided to patients with no source of third party coverage for the hospital services provided.
- Days and charges for IP/OP hospital services provided to Medicaid managed care patients.

Additional requirements:

- Field work will be completed no later than June 30th of each contract year.
- The contractor will provide the Project Manager of the Office of Program Integrity with a draft audit report no later than 90 days after completion of field work at each hospital. In addition, the contractor will provide the Project Manager with an electronic file of all supporting documentation and data supporting the contractor's audit process and findings. Upon issuance of audit report, the contractor will provide a bill for the remaining audit cost.
- The contractor will maintain all supporting documentation and data used in the contractor's audit process for a period of not less than 7 years following completion of an audit.

SECTION 4: TECHNICAL PROPOSAL

The Technical Proposal must contain the following sections:

- **Executive Summary**

  The Executive Summary is intended to highlight the contents of the Technical Proposal and to provide State evaluators with a broad understanding of the offeror's technical approach and ability.

- **Project Staffing and Staff Qualifications** – Identify the Project Director to oversee this contract and serve as chief liaison to EOHHS and provide this individual's resume. Describe the qualification and experience of key staff who will be providing audit services.

- **Capability, Capacity, and Qualifications of the Offeror**

  Vendor must have minimum five years' experience as an Audit manager and three (3) years' experience performing DSH audits is compliance with current federal regulations. Please provide a detailed description of prior related experience. Please see the requirements set forth in the Section 3: Scope of Work.

- **Quality and Completeness of Work Plan**

  Please provide a point-by-point detailed description of how the vendor proposes to provide audit services as specified in Section III, Scope of Work. The proposal must be fully responsive to each requirement and the proposer should reference each requirement that is being addressed in the proposal. The applicant must provide a detailed project work plan that clearly identifies all tasks required to conduct DSH audit services. The proposer should also identify any anticipated challenges or potential barriers in providing the audit services as well as any proposed solutions. Please see the requirements set forth in the Section 3: Scope of Work.

- **Approach & Methodology**

  Describe the approach/method for development of an effective audit program, implementation plan for the audit services, including time lines, and anticipated completion dates in line with Section 3: Scope of Work.

SECTION 5: COST PROPOSAL

Using **"Attachment A: Cost Form Page 1 of 2"**, provide a sealed and separated cost proposal for fees charged for the auditing services outlined in this proposal. Using **"Attachment A: Cost Form Page 2 of 2",** the cost amount per each report year should be totals supported by a schedule of hourly rates and estimated time for each level of staff assigned to each annual audit as described. Do not include any travel or other reimbursable cost, or other additional compensation, except as included in the hourly rates for the fiscal year.

SECTION 6: EVALUATION AND SELECTION

Proposals will be reviewed by a Technical Review Committee comprised of staff from EOHHS. To advance to the Cost Evaluation phase, the Technical Proposal must receive a minimum of 56 (80%) out of a maximum of 70 technical points. Any technical proposals scoring less than 56 points will not have the cost component opened and evaluated. The proposal will be dropped from further consideration.

Proposals scoring 56 technical points or higher will be evaluated for cost and assigned up to a maximum of 30 points in cost category, bringing the potential maximum score to 100 points.

EOHHS reserves the exclusive right to select the individual(s) or firm (vendor) that it deems to be in its best interest to accomplish the project as specified herein; and conversely, reserves the right not to fund any proposal(s).

Proposals will be reviewed and scored based upon the following criteria:

Criteria	Possible Points
Project Staffing and Staff Qualifications	15 Points
Capability, Capacity, and Qualifications of the Offeror	20 Points
Quality and Completeness of Work Plan	20 Points
Approach & Methodology	15 Points
Total Possible Technical Points	**70 Points**
Cost calculated as lowest responsive cost proposal divided by (this cost proposal) times 40 points *	30 Points
Total Possible Points	**100 Points**

*The Low bidder will receive one hundred percent (100%) of the available points for cost. All other bidders will be awarded cost points based upon the following formula:

(low bid / vendors bid) * available points

For example: If the low bidder (Vendor A) bids $65,000 and Vendor B bids $100,000 for monthly cost and service fee and the total points available are Forty (40), vendor B's cost points are calculated as follows:

$65,000 / $100,000 * 30= 19.5

Points will be assigned based on the offeror's clear demonstration of his/her abilities to complete the work, apply appropriate methods to complete the work, create innovative solutions and quality of past performance in similar projects.

Applicants may be required to submit additional written information or be asked to make an oral presentation before the technical review committee to clarify statements made in their proposal.

SECTION 7: PROPOSAL SUBMISSION

Questions concerning this solicitation may be e-mailed to the Division of Purchases at david.francis@purchasing.ri.gov no later than the date and time indicated on page one of this solicitation. Please reference **RFP # 7550421** on all correspondence. Questions should be submitted in a Microsoft Word attachment. Answers to questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information. If technical assistance is required to download, call the Help Desk at (401) 574-8100.

Offerors are encouraged to submit written questions to the Division of Purchases. **No other contact with State parties will be permitted**. Interested offerors may submit proposals to provide the services covered by this Request on or before the date and time listed on the cover page of this solicitation. Responses received after this date and time, as registered by the official time clock in the reception area of the Division of Purchases will not be considered.

Responses **(an original plus five (5) copies)** should be mailed or hand-delivered in a sealed envelope marked "**RFP#7550421: Independent Audit Services – Disproportionate Share of Hospital Claims**" to:

RI Dept. of Administration
Division of Purchases, 2nd floor
One Capitol Hill
Providence, RI 02908-5855

NOTE: Proposals received after the above-referenced due date and time will not be considered. Proposals misdirected to other State locations or those not presented to the Division of Purchases by the scheduled due date and time will be determined to be late and will not be considered. Proposals faxed, or emailed, to the Division of Purchases will not be considered. The official time clock is in the reception area of the Division of Purchases.

RESPONSE CONTENTS
Responses shall include the following:

1. One completed and signed three-page R.I.V.I.P generated bidder certification cover sheet (included in the original copy only) downloaded from the RI Division of Purchases Internet home page at www.purchasing.ri.gov.

2. One completed and signed W-9 (included in the original copy only) downloaded from the RI Division of Purchases Internet home page at www.purchasing.ri.gov.

3. **A separate Technical Proposal** describing and substantiating the bidder's; (1) understanding of this procurement, (2) capability, capacity, and qualifications to perform independent certified audits of Disproportionate Share Hospital (DSH) claims, (3) experience and background related to the services described in this solicitation, (4) the bidder's approach and/or methodology to be employed, and a work plan for accomplishing the results proposed. and (5) other factors that contribute to the bidder's ability to provide quality value-based services related to all information described earlier in this solicitation. The Technical Proposal is limited to ten (10) pages (this excludes any appendices). As appropriate, resumes of key staff that will provide services covered by this request shall be provided.

4. **A separate, signed and sealed Cost Proposal** reflecting the hourly rate, or other fee structure, proposed to complete all of the requirements of this project, including completion of the Attachment A: Cost Form.

5. In addition to the multiple hard copies of proposals required, Respondents are requested to provide their proposal in **electronic format** (**CD-Rom, disc, or flash drive**). Microsoft Word / Excel OR PDF format is preferable. Only 1 electronic copy is requested and it should be placed in the proposal marked "original".

CONCLUDING STATEMENTS

Notwithstanding the above, the State reserves the right not to award this contract or to award on the basis of cost alone, to accept or reject any or all proposals, and to award in its best interest.

Proposals found to be technically or substantially non-responsive at any point in the evaluation process will be rejected and not considered further.

The State may, at its sole option, elect to require presentation(s) by offerors clearly in consideration for award.

The State's General Conditions of Purchase contain the specific contract terms, stipulations and affirmations to be utilized for the contract awarded to the RFP. The State's General Conditions of Purchases/General Terms and Conditions can be found at the following URL: https://www.purchasing.ri.gov/RIVIP/publicdocuments/ATTA.pdf

Attachment A: Cost Form 1 of 2

INDEPENDENT AUDIT SERVICES – DISPROPORTIONATE SHARE OF HOSPITAL CLAIMS

VENDOR NAME: _____

Proposed prices for Auditing Services Bid:

The cost amount should be supported by a schedule of hourly rates and estimated time for each level of staff assigned to the annual audit report (Attachment A: Cost Form 2 of 2 Hours and Rates by Staff Level).

Indicate the lump sum amount for each auditing report by Medicaid State Plan year as described below. Do not include any travel or other reimbursable cost, or other additional compensation, except as included in the hourly rates for each **Medicaid State Plan** year ending:

2013 $_____.00, or _____dollars and no/cents.

2014 $_____.00, or _____dollars and no/cents.

2015 $_____.00, or _____dollars and no/cents.

Three Year Total: _____dollars and no/cents.

_____ _____

(Authorized official of the firm) (Date)

Attachment A: Cost Form 2 of 2

HOURS AND RATES BY STAFF LEVEL

Project Staffing and Rate Form

#	Role	$ Rate/Hr	# Hours	Total $
1	*EXAMPLE: Partner Year 1(2013)*			
2	*EXAMPLE: Director Year 1 (2013)*			
3	*EXAMPLE: Senior Manager Year 1 (2013)*			
	2013 Total			-
4	*EXAMPLE: Partner Year 2 (2014)*			
5	*EXAMPLE: Director Year 2 (2014)*			
6	*EXAMPLE: Senior Manager Year 2 (2014)*			
	2014 Total			-
7	*EXAMPLE: Partner Year 3 (2015)*			
8	*EXAMPLE: Director Year 3 (2015)*			
9	*EXAMPLE: Senior Manager Year 3 (2015)*			
	2015 Total			-
11				
12				
13				
14				
15				
...	[insert additional roles as needed]			

... Roles shown are examples. Add additional roles to reflect all positions included in this response.

* Totals must equal totals on Attachement A: Cost Form page 1 of 2

Attachment B
Disproportionate Share Hospitals

1. Eleanor Slater Hospital
2. Kent Hospital
3. Landmark Medical Center
4. Memorial Hospital
5. Miriam Hospital
6. Newport Hospital
7. Rhode Island Hospital
8. Roger Williams Hospital
9. South County Hospital
10. St. Joseph Health Services
11. Westerly Hospital
12. Women & Infants Hospital
13. Butler Hospital
14. Bradley Hospital

Attachment C
General DSH Audit and Reporting Protocol
CMS-2198-F 2

Areas of Responsibility
States:

1. States are responsible for obtaining the independent audit on an annual basis

In response to the statutory language, "independent," audits must be certified by Single State Audit Agency or any other CPA firm that operates independently from the Medicaid agency and the subject hospitals. States may not rely on non-CPA firms, fiscal intermediary, and independent certification programs currently in place to audit UCC, nor expand hospital financial statements to obtain audit certification of the hospital specific DSH limits.

The Single State Audit is an Office of Inspector General process. Although there may be some overlap in resources used to complete both audits, the DSH Audit is particular to Medicaid and is the sole responsibility of CMS to enforce and monitor and thus cannot be combined within the Single State Audit Act.

2. Providing the auditor and the DSH hospitals subject to audit with instructions on the data elements necessary to insure compliance

The DSH audit will rely on existing cost reporting tools and documents as primary sources for the data necessary to evaluate DSH payments against hospital specific DSH costs. Two of the primary source documents are the Medicare 2552-96 hospital cost report and audited hospital financial statements (and other auditable hospital accounting records). Rather than requiring that states or hospitals create new documents and potentially new financial standards, CMS will rely on the financial standards that apply to the use of these documents in their current form. Any hospital participating in the Medicare program already completes the Medicare 2552-96 cost report and is familiar with the accounting standards applicable to this document. Similarly, hospital financial statements are subject to certain financial reporting standards to produce the information that will be used in the DSH audit. Each of these documents will produce data used to develop cost and payment information for the DSH audit using the financial reporting standards applicable to each.

Developing audit protocol for use by DSH hospitals to determine costs. This protocol should include instructions identifying the relevant sections of the cost report that reflect costs eligible for inclusion in developing the hospital specific DSH limit and must replace any current DSH survey information utilized by states. This protocol should include identification of all relevant hospital cost reports and financial statements and other auditable hospital accounting records associated with the audited Medicaid State plan rate year. Situations in which a hospitals fiscal year does not coincide with the Medicaid State plan rate year, hospitals will need to provide the two (or more, if there are short-period, i.e., less than twelve-month, cost reports involved) overlapping cost reports and financial statements and other auditable hospital accounting records to properly reflect cost incurred during the full State Plan rate year.

3. Provide DSH hospitals and auditor with fee for service (FFS) Medicaid IP and OP hospital days and charges based on Medicaid Management Information System (MMIS) data for the cost reporting period(s) covering the Medicaid State plan rate year under audit.

4. Provide DSH hospitals and auditor with all information related to IP/OP hospital regular Medicaid rate payments (including all rate add-ons), all Medicaid supplemental and enhanced payments, and all DSH payments made to each DSH hospital for the cost reporting year(s) covering the State plan rate year.

5. Provide auditor with methodologies utilized by the State to determine DSH eligible hospitals under the Medicaid State plan (LIUR, MIUR, Other) and payment methodologies used to generate DSH payments under the approved Medicaid State plan.

6. Provide auditor with hospital-generated IP/OP hospital cost report information; Medicaid managed care IP/OP hospital days, charges, and payment information; and uninsured IP/OP hospital days, charges, and payment information received from DSH hospitals.

7. Report the findings of the audit to CMS within 90 days of receiving audit. In recognition of timing issues related to initiating the audit process. States may concurrently complete the Medicaid State plan rate year 2005 and 2006 audit by September 30, 2009. The report associated with Medicaid State plan rate years 2005 and 2006 are due no later than December 31, 2009 to CMS.

8. Use audit findings for rate year 2005 – 2010 to prospectively adjust DSH payments beginning with Medicaid State plan rate year 2011.

9. Use audit findings for rate year 2011 to determine over/underpayments (final report available in 2014).

DSH Hospitals:

1. Use the Medicare 2552-96 hospital cost report to determine cost center specific routine per diems and ancillary ratios of cost to charges (RCC) based on Medicare Cost Principles (Medicare cost allocation process).

2. Utilize MMIS data provided by the state for Medicaid FFS IP/OP hospital ancillary charges and Medicaid FFS IP hospital routine days.

3. Utilize hospital financial statements and other auditable hospital accounting records as source for IP/OP hospital Medicaid managed care ancillary charges and routine days and IP/OP hospital uninsured ancillary charges and routine days (individuals with no source of third party coverage). These charges and days will be used with cost center specific RCCs and per diems, respectively, to allocate hospital costs to each relevant payer category described above.

4. Utilize revenue information from financial statements and other auditable hospital accounting records to identify payments made by or on behalf of patients with no source of third party coverage for IP/OP hospital services. Note that payments for IP/OP hospital services from state-only or local-only programs for the uninsured should not be included as revenues.

5. Utilize revenue information from financial statements and other auditable hospital accounting records to identify Medicaid payments not directly paid by the State in which the hospital is located, including all

IP/OP Title XIX payments from other States (regular, supplemental and enhanced and DSH), all payments from Medicaid managed care organizations for IP/OP hospital services provided to Medicaid MCO enrollees, and all payments from other non-State sources for Medicaid IP/OP hospital services.

6. Provide state with hospital specific cost and revenue data, including backup documentation, so that independent auditor may utilize in developing audit report. Continue to provide state information already required to determine DSH qualifications (LIUR, MIUR, other).

Auditor:

1. Review State's methodology for estimating hospital's OBRA 1993 hospital-specific DSH limit and the State's DSH payment methodologies in the approved Medicaid State plan for the State plan rate year under audit.

2. Review state's DSH audit protocol to ensure consistency with IP/OP Medicaid reimbursable services in the approved Medicaid State plan. Review DSH audit protocol to ensure that only costs eligible for DSH payments are included in the development of the hospital specific DSH limit.

3. Compile hospital specific IP/OP cost report data and IP/OP revenue data to measure hospital specific DSH limit in auditable year. In determining this limit, the auditor must measure both components of the hospital specific DSH limit. To determine the existence of a Medicaid shortfall, Medicaid IP/OP hospital costs (including Medicaid managed care costs) must be measured against Medicaid IP/OP revenue received for such services in the audited State Plan rate year (including regular Medicaid rate payments, add-ons, supplemental and enhanced payments and Medicaid managed care revenues). Costs associated with patients with no source of third party coverage must be reduced by applicable revenues and added to any Medicaid shortfall to determine total eligible DSH costs.

4. Compile total DSH payments made in auditable year to each qualifying hospital (including DSH payments received by the hospitals from other States).

5. Compare hospital specific DSH costs limits against hospital specific total DSH payments in the audited Medicaid State plan rate year. Summarize findings identifying any overpayments/underpayments to particular hospitals.

Data Sources:

The following are to be considered the primary data sources utilized by states, hospitals and the independent auditors to complete the DSH audit and the accompanying report. In many instances, hospital financial and cost report periods will differ from the Medicaid State plan rate year. In these instances, hospitals should use multiple audited financial reports and hospital cost reports to fully cover the Medicaid State plan rate year under audit. The data should be directly allocated based on the months covered by the financial or cost reporting period that directly related to the Medicaid State plan period under audit. For instance, if a Medicaid State plan rate year runs from 7/1/04 to 6/30/05 but a DSH hospital receiving payments under the Medicaid State plan operates its financial and cost reporting based on a calendar year, the hospital would need to use financial and cost reports for calendar years 2004 and 2005. The hospital would allocate 50% of all costs and revenues in each financial and cost reporting period to determine costs and revenues associated with the Medicaid State plan rate year 2005.

1. MMIS Data

State MMIS generated IP hospital payments, ancillary charges and routine days for the cost reporting period(s) covering the Medicaid State plan rate year under audit for each DSH hospital.

State MMIS generated OP hospital payments and ancillary charges for the cost reporting period(s) covering the Medicaid State plan rate year under audit for each DSH hospital.

2. Approved Medicaid State Plan

LIUR, MIUR or other DSH hospital determination criteria and data used to determine eligibility for the Medicaid State plan rate year under audit.

Medicaid State Plan DSH payment methodologies for the Medicaid State plan rate year under audit.

State DSH payments to each DSH hospital for the Medicaid State plan rate year under audit.

State methodology for determining the hospital-specific DSH limit, the data used to determine such limit and the hospital-specific cost limit generated by methodology and data for the Medicaid State plan rate year under audit.

3. Medicare 2552-96 Hospital Cost Report

Medicare 2552-96 hospital cost report(s) for the Medicaid State plan rate year under audit (finalized when available, or as filed).

4. Audited Hospital Financial Statements and Other Auditable Hospital Accounting Records

Hospital revenues from Medicaid managed care organizations, Medicaid payments from other States (regular payments including add-ons, supplemental and enhanced payments, DSH payments), and Medicaid IP/OP hospital payments from all sources other than the State from hospital financial reports and records for the cost reporting period(s) covering the Medicaid State plan rate year under audit.

Hospital revenues from or on behalf of with no source of third party coverage for the hospital services provided.

Days and charges for IP/OP Medicaid hospital services for services provided to out of state Medicaid patients.

Days and charges for IP/OP hospital services provided to patients with no source of third party coverage for the hospital services provided.

Days and charges for IP/OP hospital services provided to Medicaid managed care patients.

General Cost Determination: Uncompensated Care Cost Determination

Hospitals must use the Medicare 2552-96 Hospital Cost Report(s) for the Medicaid State plan rate year to determine allowable IP/OP Medicaid service costs and costs of providing IP/OP hospital services to patients with no source of third party coverage for the hospital services provided.

The Medicare cost allocation process will be used to determine facility costs for inclusion in determining DSH eligible hospital costs. In order to provide complete financial information for the Medicaid State plan rate year under audit, hospitals must use two or more Medicare costs reports if the cost reporting period does not correspond with the Medicaid State plan rate year under audit. Once costs are allocated according to the Medicare cost allocation process, those costs should be allocated to the Medicaid State plan rate year on a pro-rata basis to develop 12 full months of costs.

1. Hospitals determine IP FFS Medicaid costs

Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a per diem is computed for each routine cost center, and a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each routine cost center are apportioned to a specific program by applying that cost center's program days to the cost center's computed per diem, and total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital inpatient fee-for-service Medicaid costs are the days and charges pertaining to hospital inpatient services furnished to Medicaid fee-for-service individuals. The primary source of the program data is the MMIS. The program days and charges must pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to inpatient hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to services paid by Title XIX fee-for-service. As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers. By applying program days defined above to the cost-report-computed per diems and applying program charges defined above to the cost report-computed cost-to-charge ratios, and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital inpatient fee-for-service Medicaid cost

2. Hospitals determine IP Medicaid managed care costs

Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a per diem is computed for each routine cost center, and a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each routine cost center are apportioned to a specific program by applying that cost center's program days to the cost center's computed per diem, and total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital inpatient Medicaid managed care costs are the days and charges pertaining to hospital inpatient services furnished to individuals under Medicaid managed care. The program data must be derived from auditable documentation and may include reports from Medicaid managed care plans. The auditable documentation must show that the program days

and charges pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to inpatient hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to Title XIX services paid by the Medicaid managed care plans. As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

By applying program days defined above to the cost-report-computed per diems and applying program charges defined above to the cost-report-computed cost-to-charge ratios, and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital inpatient Medicaid managed care cost.

3. Hospitals determine IP costs for hospital services provided to patients with no source of third party coverage

Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a per diem is computed for each routine cost center, and a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each routine cost center are apportioned to a specific program by applying that cost center's program days to the cost center's computed per diem, and total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital uninsured inpatient costs are the days and charges pertaining to hospital inpatient services furnished to individuals who have no source of third party coverage. The program data must be derived from auditable documentation. The auditable documentation must show that the program days and charges pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to inpatient hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to services furnished to individuals who have no source of third party coverage (services furnished to individuals who are covered only by state-only/local governmental programs may be included). As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

By applying the program days defined above to the cost-report-computed per diems and applying the program charges defined above to the cost-report-computed cost-to-charge ratios, and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital uninsured inpatient cost.

4. Hospitals determine OP FFS Medicaid costs

Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital outpatient fee-for-service Medicaid costs are the charges pertaining to hospital outpatient services furnished to Medicaid fee-for-

service individuals. The primary source of the program data is the MMIS. The program charges must pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to outpatient hospital services furnished and not services furnished by practitioners which can be billed separately as professional services; and c) only to services paid by Title XIX fee-for-service. As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

By applying the program charges defined above to the cost-report-computed cost-to-charge ratios and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital outpatient fee-for-service Medicaid cost.

5. Hospitals determine OP Medicaid managed care costs

Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital outpatient Medicaid managed care costs are the charges pertaining to hospital outpatient services furnished to individuals under Medicaid managed care. The program data must be derived from auditable documentation and may include reports from Medicaid managed care plans. The auditable documentation must show that the program charges pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to OP hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to Title XIX services paid by the Medicaid managed care plans. As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

By applying program charges defined above to the cost-report-computed cost-to-charge ratios and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital outpatient Medicaid managed care cost.

6. Hospitals determine OP costs for hospital services provided to patients with no source of third party coverage

Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital uninsured outpatient costs are the charges pertaining to hospital outpatient services furnished to individuals who have no source of third party coverage. The program data must be derived from auditable documentation. The auditable documentation must show that the program charges pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to OP hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to services furnished to individuals who have no

source of third party coverage (services furnished to individuals who are covered only by state-only/local governmental programs may be included). As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.
By applying the program charges defined above to the cost-report-computed cost-to-charge ratios and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital uninsured outpatient cost.

7. Hospital report revenues from Medicaid managed care organizations, Medicaid payments from other States (regular payments including add-ons, supplemental and enhanced payments, DSH payments), and other non-State Medicaid payments

Since the State's MMIS system will not have information about payments generated from Medicaid managed care organizations or Medicaid and DSH payments from other States and other non-State sources, hospitals must use their financial statements and other auditable hospital accounting records to identify:

All Medicaid managed care payments received during the cost reporting period(s) covering the Medicaid State plan rate year under audit. Any managed care payments received that include payments for services other than those that qualify for IP or OP hospital services must be separated to include that portion of the payment applicable to IP or OP hospital services. If the hospital cannot separate the component parts of a managed care payment, the full amount of the payment must be counted as in IP/OP hospital managed care payment.

All Medicaid payments received from out of state during the cost reporting period(s) covering the Medicaid State Plan rate year under audit. Hospitals must separately identify a) Medicaid regular rate payments (including add-ons); b) supplemental Medicaid payments, and; c) DSH payments. All Medicaid payments received during the cost reporting period(s) covering the Medicaid State plan rate year under audit from non-State sources not already accounted for, including payments from or on behalf of patients for Medicaid services.

8. Hospital report revenue from or on behalf of patients with no source of third party coverage for the hospital services provided

Since the State's MMIS system will not have information about payments by or on behalf of patients with no source of third party coverage for the hospital services provided, hospitals must use their financial statements and other auditable hospital accounting records to identify:

All payments received during cost reporting period(s) covering the Medicaid State plan rate year under audit by or on behalf of patients with no source of third party coverage. There will be no attempt to allocate payments received during the state plan rate year to services provided in prior periods. Since the goal of the audit is to determine uncompensated DSH costs in a given Medicaid State plan rate year, all payments received in the year will be counted as revenue to the hospital in that same year. It is understood that some costs incurred during the State Plan rate year under audit may be associated with future revenue streams (legal decisions, payment plans, and recoveries) but that the payments are not counted as revenue until actually received.

IP or OP hospital payments received from state or local government programs for individuals with no source of third party coverage for the hospital services they received should not be included as a revenue in this category.

9. Auditor applies MMIS generated total IP/OP hospital Medicaid FFS payments (other than DSH) to total IP/OP hospital Medicaid FFS cost

10. Auditor applies IP/OP hospital Medicaid managed care revenues against IP/OP hospital Medicaid managed care costs

11. Auditor applies IP/OP hospital revenues for patients with no source of third party coverage against the costs for IP/OP hospital services provided to such individuals

12. Sum of steps 9-11 are summed to determine the total amount of costs eligible for DSH reimbursement and considered the OBRA 1993 hospital specific DSH limit

13. Compare DSH payments to the amount determined in step 12

Attachment D
Additional Information on the DSH Reporting and Audit Requirements

Best Available Information/Cost Report Procedures

1. How can an independent auditor certify that DSH payments do not exceed the hospital-specific DSH limits if data used for calculating the limits is derived, at least in part, from as-filed Medicare cost reports?

Certification means that the independent auditor engaged by the State follows the criteria of the Federal audit regulation and completes the verification, calculations and report under the professional rules and generally accepted standards of audit practice. This certification would include an assessment of the State's audit protocol to ensure that the Federal regulation is satisfied, an opinion for each verification detailed in the regulation, and a determination of whether or not the State made DSH payments that exceeded any hospital-specific DSH limit in the Medicaid State plan rate year under audit. The certification should also identify any data issues or other caveats that the auditor identified as impacting the results of the audit.

We expect that reports and audits will be based on the best available information. If audited Medicare cost reports are not available within the timeframe allowed for the reporting and audit submission, the DSH report and audit may need to be based on Medicare cost reports as filed. However, in the final rule, CMS modified the timeline for report and audit submission to allow States additional time for the inclusion of the most accurate and complete data possible. The required reports and audits may be submitted as late as the last day of the Federal fiscal year ending three years after the end of the Medicaid State plan rate year, with a special timing provision for the audits for 2005 and 2006, which will be due by December 31, 2009. Additionally, CMS has developed a General DSH Audit and Reporting Protocol that should assist States and auditors in utilizing information from each data source and developing methods to determine uncompensated costs of furnishing hospital services to the Medicaid and uninsured populations. The protocol is available on the CMS website at www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptProtocol.pdf.

It should be noted that in light of States' concerns regarding budget cycles, planning complications, and the economic downturn, CMS has determined that it will apply a flexible enforcement strategy designed to ensure that States have sufficient time to properly implement the new requirements without undue hardship. Thus, CMS will not find a State to be out of compliance with the DSH reporting and auditing requirements for the initial (2005 and 2006) Medicaid State plan rate years until December 31, 2010. Pursuant to the provisions of the regulation, independent audits must begin with Medicaid State plan year 2005 and must be completed no later than September 30, 2009, for the State plan rate years 2005 and 2006. Audits and reports for State plan rate years 2005 and 2006 are due to CMS on or before December 31, 2009.

2. If as-filed Medicare cost reports are used to calculate hospital-specific DSH limits, do limits have to be adjusted to reflect the final settlement of the cost report or the outcome of cost report appeals?

We expect that reports and audits will be based on the best available information. If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed. Most hospital cost reports are finalized within two years of the period being audited but there is always the possibility of post-audit adjustments. To the extent that such adjustments to cost reports affects Medicaid payments, States should notify CMS of the adjustments to the cost reports and any subsequent DSH audit report changes as well as make appropriate prior period adjustments through the MBES/CBES system. Additionally, we would anticipate the auditor's certification would identify any data issues or other caveats that the auditor has identified as impacting the results of the audit.

The statutory authority instructed States to report and audit specific payments and specific costs. Consistent with that provision, States must perform audits associated with defined periods of time and must identify the actual costs incurred and payments received during that defined time period. In order for the audits to properly measure these elements and in consideration of the many comments related to retroactivity and timing issues associated with gathering the data necessary to identify the costs and revenues, CMS has made several revisions to the final rule including identifying that: (i) the Medicaid State plan rate year 2005 is the first time period subject to the audit; and, (ii) the deadline on reporting the audit findings has been extended to at least three full years after the close of the Medicaid State plan rate year subject to audit.

The required reports and audits may be submitted as late as the last day of the Federal fiscal year ending three years after the end of the Medicaid State plan rate year, with a special timing provision for the audits for 2005 and 2006, which will be due by December 31, 2009. This three year period accommodates the one-year concern expressed in many comments regarding claims lags and is consistent with the varying cost report period and adjustments.

3. Data derived from multiple cost report years might have to be used in fulfilling audit and reporting requirements for a given State plan rate year. In order to complete reporting and auditing requirements relating to State plan rate years 2005 and 2006, for the 2005 and 2006 reports, would it be acceptable to obtain 2004 and 2007 costs from submitted or unreviewed cost reports?

In instances where the hospital financial and cost reporting periods differ from the Medicaid State plan rate year, States and auditors may need to evaluate multiple audited hospital financial reports and cost reports to fully cover the Medicaid State plan rate year under audit. Typically, at most, two financial and/or cost reports should provide the appropriate data. Please note that there are some circumstances where more than two cost reports are needed to cover a State plan year. Some occasions call for a hospital to file short-period cost reports within a normal 12-month cost reporting period. For example, if there is a change of ownership in the middle of a fiscal period, the hospital will have to file more than one cost report during its 12-month fiscal period. The data may need to be allocated based on the months covered by the financial or cost reporting period that are included in the Medicaid State plan period under audit. CMS has developed a General DSH Audit and Reporting Protocol to assist States in using the information from each source identified above and developing the methods under which costs and revenues will be determined. The protocol is available on the CMS website at w<u>ww.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptProtocol.pdf</u>.

We expect that all reports and audits will be based on the best available information. If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed. Moreover, in order to ensure a period for developing and refining audit practices, we are providing

for a transition period through Medicaid State plan rate year 2010, before audit results will be given weight other than in making prospective estimates of hospital costs for the purposes of ongoing DSH payments.

4. Can independent auditors utilize a risk-based approach to auditing hospitals or utilize some materiality guideline in developing different levels of data analysis for different hospitals? Additionally, does CMS expect that all hospitals are audited by the independent auditor annually?

The DSH audit and report is a necessary part of the administration of the Medicaid program. The purpose of the audit is to ensure that States make DSH payments under their Medicaid program that are in compliance with section 1923 of the Act. The audit does not encompass the review of the State's overall Medicaid program; it simply ensures that one portion of the program is conducted in line with Federal statutory limits. In addition, the DSH audit will rely on financial and cost report data provided by hospitals that are subject to generally accepted accounting principles as part of their primary reporting function. There is no statutory authorization for an exception to audit and reporting requirements with respect to hospitals that receive DSH payments. The audit and reporting requirements under section 1923(j) of the Act apply to all States that make DSH payments, with respect to each hospital receiving a DSH payment. The statute further requires that CMS obtain information sufficient to verify that such payments are appropriate. Relying on a sample of cost reports and financial information will not ensure that each DSH payment is appropriate and does not exceed the hospital-specific DSH limit.

The data elements necessary for the State to complete the DSH audit and report should, in part, be information the State already gathers to administer the DSH program. The responsibility of the auditor is to measure DSH payments received by a hospital in a particular year against the eligible uncompensated care costs of that hospital in that same year as determined using the data provided in the cost, utilization and financial reporting documents described in the preamble to the final rule. Additionally, auditing a State's overall DSH payment methodology will not ensure that DSH payments to each hospital do not exceed the statutorily required hospital-specific DSH limit.

Finally, in order to certify to the verifications, the auditors should follow generally accepted auditing practices and requirements to assure a thorough and complete audit has been conducted. The auditor must develop sufficient confidence in the data to certify the results for the State plan rate year subject to the audit. The final rule does not eliminate any flexibility that independent auditors might have in using accepted professional methodologies to conduct the audit and to certify to the verifications. However, the independent certified audits required to be submitted must be performed in compliance with section 1923(j) and implementing regulations as a condition for receiving Federal payments under section 1903(a)(1) and 1923 of the Act.

5. If DSH payments are based on hospital-specific DSH limits from prior year audits, recoupments and DSH payment redistribution might be necessary on an annual basis. How does CMS expect States to deal with this cost and with the potential hardship to the hospitals?

This regulation does not require States to implement retrospective DSH payment methodologies or otherwise change the basic approach to DSH payment used by the States. Nor does it require delay in making DSH payments consistent with the authority of the approved Medicaid State plan. CMS recognizes that States may need to estimate uncompensated care to determine DSH payments in an upcoming Medicaid State plan rate year, indeed, this is currently the way most States distribute DSH payments. The

regulation is intended to ensure that those estimates do not exceed the actual hospital-specific limit in the year in which the payments are received.

States retain considerable flexibility in setting DSH State plan payment methodologies to the extent that such methodologies are consistent with 1923(c) and all other applicable statute and regulations. This regulation provided for time frames that should provide States with accurate information with which to determine prospective DSH payments and time to review and adjust rates once actual eligible uncompensated care amounts are determined. States will have to determine how to best ensure that prospective DSH methodologies do not result in payments that exceed hospital-specific DSH limits, either by revising those methodologies or by providing for reconciliation of prospective payments with those limits. Because FFP is only available for DSH payments that do not exceed the hospital-specific limit, some States may determine that a retrospective DSH payment methodology or a DSH reconciliation is a reasonable way to manage its DSH allotment.

CMS, as always, is available to offer technical assistance to States in developing such methodologies. Additionally, CMS included a transition period in the regulation to ensure that States may adjust prospective estimates to avoid any immediate adverse fiscal impact.

1. **The final regulation requires a determination of whether or not the State made DSH payments that exceeded the hospital-specific DSH limit for any hospital in the Medicaid State plan rate year under audit. If the DSH audit identifies DSH payments made to a hospital in excess of the hospital-specific DSH limit, how should States treat such payments if the hospitals are no longer eligible for DSH, are bankrupt, or no longer exist?**

As stated in the final rule, beginning in Medicaid State plan rate year 2011, to the extent that audit findings demonstrate that DSH payments made in that year exceed the documented hospital-specific cost limits, CMS will regard them as representing discovery of overpayments to providers that, pursuant to 42 CFR Part 433, Subpart F, triggers the return of the Federal share to the Federal government (unless the DSH payments are redistributed by the State to other qualifying hospitals as an integral part of the audit process). This is not a "penalty" but instead reflects adjustment of an overpayment that was not consistent with Federal statutory limits. However, we note that, to the extent that States wish to redistribute any DSH payments that exceeded a particular hospital-specific limit, the Federally approved Medicaid State plan must reflect that payment policy and allow for individual payment adjustments based on the audit. Further, States need not refund the Federal share of overpayments made to providers who are determined to be bankrupt or out of business in accordance with 42 CFR 433.318.

7. **To meet the reporting and auditing requirement, States must perform audits associated with defined periods of time and must identify the actual costs incurred and payments received during that defined time period. Can a State use adjudicated claims date, or must they change to admission or discharge date, which is reflected in the comment and response of the DSH final rule?**

Section 1923(g) of the Social Security Act imposes a limit that is based in part on a year's worth of services. The preamble language is merely illustrative of two approaches some States may already use to determine the volume of Medicaid services and payments to be included in the yearly limit and was not intend to be all inclusive. Adjudicated claims date would be another acceptable approach to determine the amount of services furnished during the year. However, the approach used must be consistent with the

approved State plan language for the specified time period and should be clearly defined in the audit report.

8. What does the final rule mean by the term Medicaid State plan rate year?

In using the term State plan rate year, we recognize that while many States may set rates on a State fiscal year basis, some States set rates on a calendar or other annual basis and establish DSH limits accordingly. The State plan rate year is therefore the 12-month period defined by a State's approved State plan in which the State estimates eligible uncompensated care costs and determines corresponding DSH payments as well as other Medicaid payment rates.

9. Some States utilize certified public expenditures (CPE) to finance the non-Federal share of DSH payments made up to hospital-specific DSH limits. Should States modify existing State plan provisions and/or special terms and conditions (STC) of section 1115 demonstrations in instances where the approved State plan and/or STCs methods for calculating costs for these CPE-funded payments differ from the method for calculating the hospital-specific limit required by the final regulation and associated DSH General Auditing and Reporting Protocol?

To ensure that claims for DSH expenditures do not exceed hospital-specific DSH limits, States should modify their methods for calculating CPE-funded DSH payments to the extent that the approved State plan and/or STCs methods vary from that required by the final DSH audit regulation and associated DSH General Auditing and Reporting Protocol. If this requires a modification to the State plan or 1115 STCs, State should submit a State plan amendment or section 1115 demonstration amendment, respectively. The final regulation does include a transition period to ensure that States may adjust uncompensated care estimates prospectively to avoid any immediate adverse fiscal impact and to assist States in ensuring that future DSH payments do not exceed the hospital-specific DSH limit. Additionally, to permit States an opportunity to develop and refine audit procedures, audit findings from Medicaid State plan rate year 2005-2010 will be limited to use for the purpose of estimating prospective hospital-specific uncompensated care cost limits in order to make actual DSH payments in the upcoming Medicaid State plan rate years. CMS is not requiring retroactive collection for Medicaid State plan rate years that have already passed. By using that time to improve State DSH payment methodologies, States may avoid circumstances in which DSH payments that exceed Federal statutory limits must be recouped from hospitals.

Audit Reports

10. Please provide clarification on the extent to which the State may rely upon hospitals to perform the DSH audit. Please clarify whether the State may rely upon hospitals' current or expanded financial audits for the certification of the hospital-specific DSH limits.

As stated in the final rule, the responsibility for certification of an independent audit rests with the State. States must engage an independent auditor to certify that the requirements of the Federal regulation are satisfied, to provide an opinion for each specified verification, and to make a determination as to whether any DSH payments exceeded any hospital's specific DSH limit. States would not meet the independent audit certification requirement by merely expanding audits of hospital financial statements to obtain audit

certification from each hospital. However, States may utilize an independent auditor to independently analyze and certify information submitted by each hospital to the State.

Furthermore, the mere fact that a specific auditing entity completes a Medicaid financial audit for a hospital does not necessarily preclude the State from contracting with that auditing entity to complete the independent DSH audit. To the extent that the auditor attests in the DSH audit report that they meet the requirements for auditor independence described in Chapter 3 of the General Accounting Organizations General Audit Standards (GAGAS), an auditing entity of any hospital's financial audit may be eligible to complete the certified DSH audit for the State.

11. Please provide guidance on what auditing standards and procedures should be used in undertaking the DSH audit as well as what type of report auditors should issue.

The purpose of the DSH audit is to ensure that Medicaid DSH payments comply with Federal statutory limits. The DSH audit will necessarily rely upon financial and cost report data that are subject to generally accepted accounting principles, and accounting principles specific to hospital accounting under federal grant programs.

Audit procedures that are in accordance with applicable industry standards would meet the criteria established within the final rule if the auditors certify the audit in accordance with the definition of "independent certified audit" as defined at 455.301 of the final rule. We understand that the term "certification" may have specific meaning within the auditing profession. Our use of the term "certification" for purposes of DSH audits is limited to the actions set forth at 455.301. For this purpose, certification means that the auditor attests to qualifying as an independent auditor, has reviewed the criteria of the Federal audit regulation and has completed the verification, calculations, and report under professional rules and generally accepted standards of audit practice. To the extent that the auditor decides that specific methods (which may include requirements beyond the scope of those specifically outlined within the regulation and protocol) are necessary to certify to the audit in accordance with the certification criteria at 455.301 and 455.304, then the auditor should employ these methods. As noted in 455.301, the certification should identify any data issues or other caveats that the auditor identifies as impacting the results of the audit.

We look forward to working with States in refining the auditing process throughout the transition period. Once States and CMS gain greater experience with the auditing process, CMS will work further with States to highlight best practices and auditing methods.

12. The 2005 and 2006 DSH audit reports are to be completed by September 30, 2009, and must be submitted to CMS by December 31, 2009. Are States able to grant extensions to auditors to complete the audits subsequent to September 30, if the final report is still delivered to CMS by December 31, 2009?

CMS has determined that it will apply a flexible enforcement strategy designed to ensure that States have sufficient time to properly implement the new requirements without undue hardship. Thus, CMS will not find a State to be out of compliance with the DSH reporting and auditing requirements for the initial (2005 and 2006) Medicaid State plan rate years until December 31, 2010. We do not anticipate any further delay of compliance enforcement, or any delay of compliance enforcement for subsequent audit years.

Even though CMS will be delaying compliance enforcement, CMS expects that States will be making good faith efforts to comply with the new requirements. We asked each State to identify, and to provide in writing to its respective CMS Associate Regional Administrator, a contact individual by September 30, 2009 to brief CMS representatives on the State's compliance status and progress. Based on those discussions, some States were/may be asked for detailed information about compliance efforts.

The final rule included a transition period recognizing that auditing processes and techniques may need to be refined. This transition period lasts through Medicaid State plan rate year 2010, before audit results will be given weight other than in making prospective estimates of hospital costs for the purposes of ongoing DSH payments. In the transition, CMS will work with States that make a good faith effort to fulfill all of the DSH reporting and auditing requirements and that also submit a final report to CMS by the December 31 deadline. It should be noted that States will still be expected to make DSH payments that conform to the hospital-specific limits beginning in 2011.

13. The rule states that the 2005 and 2006 DSH audit reports are to be submitted to CMS by December 31, 2009. What method will CMS use to determine submission date?

CMS has determined that it will apply a flexible enforcement strategy designed to ensure that States have sufficient time to properly implement the new requirements without undue hardship. CMS will not find a State to be out of compliance with the DSH reporting and auditing requirements for the initial (2005 and 2006) Medicaid State plan rate years until December 31, 2010. We do not anticipate any further delay of compliance enforcement, or any delay of compliance enforcement for subsequent audit years. We asked each State to identify, and to provide in writing to its respective CMS Associate Regional Administrator, a contact individual by September 30, 2009 to brief CMS representatives on the State's compliance status and progress. Based on those discussions, some States were/may be asked for detailed information about compliance efforts.

When States have completed the DSH audits and reports, they should submit the required reports and audits electronically via email to the Associate Regional Administrator of their respective CMS Regional Office on or before the applicable deadline. States are encouraged to carbon copy their Regional Office National Institutional Reimbursement Team (NIRT) representative and CMS Regional Office State representative as well. The receipt date will be the email creation and submission date as indicated on the email.

Certified audits should be submitted in a PDF format using an Adobe Acrobat application and should contain a PDF file of the completed reporting element template. All audit files should be submitted in zip data compression formats to ensure ease of electronic delivery.

CMS is exploring the possibility of including the required reporting elements into the MBES process and will provide additional guidance in the near future. Absent the MBES reporting process, States should submit the report as an excel spreadsheet in addition to the PDF format included in the certified audit report.

14. Is CMS planning on setting a DSH payment threshold below which some or all of the reporting requirements will be waived?

There is no statutory authorization for an exception to audit and reporting requirements with respect to hospitals that receive DSH payments. The audit and reporting requirements under section 1923(j) of the

Act apply to all States that make DSH payments, with respect to each hospital receiving a DSH payment. As we noted in the preamble to the final rule, the statute requires that each State report to CMS data, and submit a certified audit, that verifies that all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments and that such payments do not exceed the hospital-specific DSH limit. Even if a State only makes DSH payments under its approved Medicaid State plan that relate to the uncompensated care of providing inpatient and outpatient hospital services to Medicaid individuals (that is, Medicaid shortfall), it would be possible for payments to a hospital to exceed the hospital-specific limit if the hospital had a surplus in furnishing hospital services to the uninsured. While this may be an unlikely circumstance, we cannot at this time be certain that it never occurs. Therefore, in such a circumstance we will accept reporting limited to Medicaid uncompensated care only when the hospital provides a certification that it incurred additional uncompensated care costs serving uninsured individuals. When we review certified audit reports submitted by States, we will consider whether more flexibility would be warranted, and we may address the issue in future reporting instructions. However, prior to receiving the first set of annual State reports, CMS is not contemplating any changes to the reporting requirements.

Auditor Independence

15. What constitutes an independent auditor?

Medicaid regulations at 42 CFR 455.301 define a certified independent audit in part to mean an audit that is conducted by an auditor that operates independently from the Medicaid agency or subject hospital. The intent is for the auditor to be fully able to render objective and impartial judgment on all matters relating to a required DSH audit. Examples of potential conflicts for audit entities would be: calculating a State's DSH payments under the Medicaid State plan; developing State plan DSH payment methodologies for States; preparing uninsured/Medicaid source documents and/or originating data relating to the DSH program on behalf of subject hospitals and/or the State; serving as auditor to any subject hospital or the State agency; and possessing a direct or indirect financial interest in the State's DSH program. In this context, independence generally means that the audit organization and individual auditor is free of any impairment that may in fact or in appearance preclude an impartial opinion or reporting.

States are responsible for ensuring that no possible impairment exists between the auditing organization/auditors and the Medicaid agency and/or hospital. Within the auditing profession, standards have developed to help guide auditors and/or their clients with respect to independence and impairments that might potentially compromise it. The final rule provides that these principles are to be applied to Medicaid DSH audits. The General Accountability Office (GAO), in Chapter 3 of its most recent revision to Government Auditing Standard, identifies specific criteria for independence and outlines impairments to independence in government auditing practices (http://www.gao.gov/govaud/govaudhtml/index.html).

While we believe these generally accepted standards relating to independence in government auditing to be well understood by the auditing profession and would expect their correct application to the required audits, there are some situations that may warrant additional review. For instance, section 3.29 of the General Standards outlines non-audit services that impair auditor independence. The section states certain non-audit services directly support an entity's operations and impair an audit organization's ability to meet overarching audit principles (in this case we would consider the "entity" to be the Medicaid agency and/or hospital). Some examples of these types of services that may impair independence for purposes of conducting the DSH audit include:

a. maintaining or preparing the audited entity's basic accounting records or maintaining or taking responsibility for basic financial or other records that the audit organization will audit;
b. posting transactions (whether coded or not coded) to the entity's financial records or to other records that subsequently provide input to the entity's financial records;
c. determining account balances or determining capitalization criteria;
d. designing, developing, installing, or operating the entity's accounting system or other information systems that are material or significant to the subject matter of the audit;
e. providing payroll services that (1) are material to the subject matter of the audit or the audit objectives, and/or (2) involve making management decisions;
f. providing appraisal or valuation services that exceed the scope described in paragraph 3.28 c;
g. recommending a single individual for a specific position that is key to the entity or program under audit, otherwise ranking or influencing management's selection of the candidate, or conducting an executive search or a recruiting program for the audited entity;
h. developing an entity's performance measurement system when that system is material or significant to the subject matter of the audit;
i. developing an entity's policies, procedures, and internal controls;
j. performing management's assessment of internal controls when those controls are significant to the subject matter of the audit;
k. providing services that are intended to be used as management's primary basis for making decisions that are significant to the subject matter under audit;
l. carrying out internal audit functions, when performed by external auditors; and
m. serving as voting members of an entity's management committee or board of directors, making policy decisions that affect future direction and operation of an entity's programs, supervising entity employees, developing programmatic policy, authorizing an entity's transactions, or maintaining custody of an entity's assets.

Further examples of such potential conflicts for audit entities would be: providing audit services for the Medicaid program generally (not specifically related to DSH payments) such as auditing cost reports or determining Medicaid service rates; serving as auditor to any subject hospital or the State agency; and possessing a direct or indirect financial interest in the State's Medicaid program.

There are situations in which sufficient firewalls exist between such services that would serve to eliminate the potential conflict regarding auditor independence. In such cases, States must explain why such an audit firm meets the GAGAS independence standards despite the appearance that the auditing entity is not independent. The audit firm must also declare its independence in the audit and report submitted to CMS. States should look to the General Auditing Standards in their entirety to ensure that no possible impairments to independence exist.

For State plan rate year 2007 and thereafter, auditing organizations/auditors must submit a signed statement declaring independence of the respective Medicaid agency and hospitals. This statement should be included with the audit and report submitted to CMS on an annual basis.

16. Can States use provider-related donations, assessments, taxes on, or other similar funding arrangements with DSH hospitals to fund the required audits?

The DSH audit requirements and final rule do not supersede any Medicaid provisions relating to donations and taxes. As a practical matter, we do not see how a State could rely on "voluntary" donations to fund

required Medicaid programs and expenses. As indicated in the preamble, section 1923(j) makes these DSH audit and reports a Medicaid program requirement and as such States are responsible for funding the costs to fulfill them just as they are any other Medicaid administrative costs. To the extent a State's payment methodology for the audits and reports would be prohibited as an impermissible tax or donation, a State may not employ that methodology for purposes of funding the audits. States may not impose DSH fees or require financial participation in the funding of the audit as a condition for receiving DSH payments. Furthermore, to the extent that a provider-related donation presumed to be bona fide contains a hold harmless provision, it would not be considered a bona fide donation.

Revenue Recognition

17. How should States, hospitals, and auditors treat Medicaid payments received after the completion of the audit for a particular Medicaid State plan rate year?

In recognition of potential delays in obtaining needed information, we have extended the period for ongoing report and audit submission until the end of the Federal fiscal year that is at least three years after the close of the Medicaid State plan rate year. We believe that hospitals would have received most Medicaid, DSH payments, and other payments associated with that Medicaid State plan rate year.

Based on the modifications to the audit and reporting deadlines, the existing requirement at 42 CFR 447.45(d) for provider claims to be filed within a year from the date of service and promptly paid by the State, and the existing two-year timely claim filing requirement at 45 CFR 95.7, there should not be a significant adjustment to Medicaid payments that would warrant a corrected audit and report. To the extent that a significant adjustment to Medicaid payments occurs and States claim Federal matching dollars (or return Federal matching dollars) as a prior period adjustment, States should correct the audit and report by indicating post-audit adjustments to Medicaid and DSH payments (or uncompensated care costs if Medicaid payment adjustments affect the Medicaid shortfall). When post-audit retroactive adjustments to Medicaid payments are not significant, the payments should be measured during the audit of the Medicaid State plan rate year in which the revenues are received.

18. The final regulation and the preamble address which State plan rate year revenues apply to for purposes of calculating a hospital-specific DSH limits. It appears, however, that the preamble requires Medicaid payment offsets occurring after the completion of the DSH audit be applied duplicately in calculating hospital-specific DSH limits for two distinct State plan rate years. Can you confirm that these Medicaid revenues should be applied in calculating hospital-specific DSH limits for only one Medicaid State plan rate year?

Medicaid revenues identified in the post-audit period must only be applied against one State plan rate year for purposes of calculating hospital-specific DSH limits.

19. Against which Medicaid State plan rate year are revenues received by a hospital by or on behalf of either 'self-pay' or uninsured individuals during the Medicaid State plan rate year under audit offset?

The General DSH Audit and Reporting Protocol provides clarification regarding all payments received during cost reporting period(s) covering the Medicaid State plan rate year under audit by or on behalf of

patients with no source of third party coverage. There will be no attempt to allocate payments received during the State plan rate year to services provided in prior periods. Since the goal of the audit is to determine uncompensated DSH costs in a given Medicaid State plan rate year, all payments received in the year will be counted as revenue to the hospital in that same year. It is understood that some costs incurred during the State Plan rate year under audit may be associated with future revenue streams (legal decisions, payment plans, and recoveries) but that the payments are not counted as revenue until actually received.

Allowable Costs/Medical Necessity

20. Will CMS be issuing guidance on what constitutes medically necessary services?

CMS does not intend to issue guidance on what constitutes medically necessary services. CMS will continue to allow States flexibility in determining medical necessity under their individual Medicaid programs within the guidelines of the Social Security Act provided at 1902(a)(30) and 1902(a)(19), and the implementing regulations at 42 CFR 440.230(d), which state "The [Medicaid] agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." Generally, services that are considered reimbursable under the Medicaid State plan would also be considered as necessary services when calculating a hospital's eligible uncompensated care cost.

21. Are States required to follow only Medicare reasonable cost principles, or will they be allowed to establish allowable cost rules that may differ from Medicare?

As noted in the preamble to the final rule, section 1923(g)(1) of the Act provides for a Federal limitation based on costs that must be calculated in accordance with Federal accounting standards. The same methods used in preparing the Medicare 2552-96 cost report should be applied in determining costs to be used in calculating the hospital-specific DSH limits.

Hospitals' Medicare cost reports, audited financial statements, and accounting records should contain the information necessary for reporting and auditing responsibilities, in combination with information provided by the States' Medicaid Management Information Systems (MMIS) and the approved Medicaid State plan governing the Medicaid payments made during the audit period. The CMS developed General DSH Audit and Reporting Protocol will assist States and auditors in using information from each of these sources to determine allowable uncompensated care costs consistent with the statutory requirements. The protocol is available on the CMS Web site at:
www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptProtocol.pdf. 7323572 -66 of 71-

22. If a State allows for graduate medical education as an allowable component of cost and is included in the Medicaid State Plan, should the State require the filing of Medicaid cost reports that incorporate the graduation medical education in the determination of program cost?

All costs that are associated with services that are defined and reimbursed under the approved Medicaid State plan as inpatient hospital services and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage may be included in calculating the hospital-specific DSH limit. To properly capture these costs in the hospital-specific DSH limit, State's should include these costs as part of the Medicare 2552-96 cost report step-down process and utilize the General DSH Audit and Reporting Protocol.

To the extent that a State allows graduate medical education (GME) as a component of cost and it is reimbursed under the Medicaid State plan, the State can include these costs in determining hospital-specific DSH limits. Please be reminded that the State still must use the cost reporting and apportionment process as prescribed by the Medicare 2552-96 identified in the General DSH Audit and Reporting Protocol.

23. "How should States treat unpaid Medicaid days or charges for purposes of calculating hospital-specific DSH limits?" What if the unpaid days are a result of untimely filing or a hospitals failure to seek prior authorization?

The hospital-specific DSH limit includes the costs incurred during the year of furnishing hospital services to Medicaid beneficiaries and the uninsured, net of Medicaid payments and payments made by or on behalf of the uninsured. To be included as Medicaid cost in the limit, a hospital service must be included in a State's definition of an inpatient hospital service or outpatient hospital service under the approved State plan and furnished to Medicaid eligible individuals.

Individuals with Medicaid or other third party coverage are not considered as uninsured under 1923(g)(1). Improper billing by a provider does not change the status of an individual as insured or otherwise covered. In no instance should costs associated with claims denied by a health insurance carrier for such a reason be included in the calculation of hospital-specific uncompensated care costs.

24. A Medicaid program in a State covers speech therapy services for beneficiaries under 18 years of age. A hospital in that State provided speech therapy to a Medicaid enrollee who was over 18 and claimed the services as uninsured care. Are the costs incurred by the hospital in providing the speech therapy service allowed to be included in the calculation of hospital-specific DSH limits?

In this example the costs associated with speech therapy services can be included in the calculation of hospital-specific DSH limits to the extent that such services are treated as "hospital services" under the State plan because the patient is eligible for Medicaid. The hospital-specific limit is based on the costs incurred for furnishing ``hospital services" and does not include costs incurred for services that are outside either the State or Federal definition of inpatient or outpatient hospital services. While States have some flexibility to define the scope of ``hospital services," States must use consistent definitions of ``hospital services." Hospitals may engage in any number of activities, or may furnish practitioner or other services to patients, that are not within the scope of ``hospital services," including speech therapy. A State cannot include in calculating the hospital-specific DSH limit cost of services that are not defined under its Medicaid State plan as a Medicaid inpatient or outpatient hospital service.

Determination of Uninsured Status

25. CMS seems to contradict itself in replying to the question of including patients who lack coverage for the service provided but not necessarily any coverage at all. CMS states that they have never read the statute to be service-specific and believe that such an interpretation would be inconsistent with the broad statutory references to insurance or other coverage. Furthermore, CMS replies that such a reading would result in cost shifting from private sector coverage to the Medicaid program. However, in a January 10, 1995 letter to Donna Checkett, Chair of the State Medicaid Director's Association, CMS clarified that: "it would

be permissible for States to include in their determination of uninsured patients those individuals who do not possess health insurance which would apply to the service which the individual sought". Is it CMS's position now that it depends on whether the individual has creditable coverage consistent with 45 CFR 144 and 146 and not whether the specific service is covered?

Section 1923(g)(1) of the Act refers to the costs of hospital services furnished by the hospital to individuals who have no health insurance (or other source of third party coverage). This language is not service-specific and any interpretation to the contrary would be inconsistent with the broad statutory references to insurance or other coverage. In an effort to adhere to a more accurate representation of the broad statutory references to insurance or other coverage; and to delineate more definitively the meaning of the term uninsured, CMS clarified the populations for which hospitals may calculate uncompensated care costs. We interpret the phrase ''who have health insurance (or other third party coverage)'' to broadly refer to individuals who have creditable coverage consistent with the definitions under 45 CFR Parts 144 and 146, as well as individuals who have coverage based upon a legally liable third party payer. Creditable coverage would include coverage of an individual under a group health plan, Medicare, Medicaid, a medical care program of the IHS or tribal organization, and other examples as outlined in the rules relating to creditable coverage at 45 CFR 146.113.

26. Does an advance beneficiary notice for a medically necessary procedure satisfy the requirement that "[c]laims denied by a health insurance carrier, including a Medicaid contracted managed care organization, for any reason other than the inpatient/outpatient service or services provided were not covered services within the individuals health benefit package are furnished to individuals who have health insurance coverage"?

The quoted sentence is taken out of context and does not reflect a "requirement." The underlying requirement is that, to be included in the calculation of the hospital-specific limit, the services at issue must be furnished to an individual who does not have "health insurance (or other source of third party coverage)." As indicated in the sentence prior to the quoted sentence. "[t]he costs of services for individuals who have health insurance are not included in calculating the hospital-specific limit, even if insurance claims for that particular service are denied for any reason." And the following sentence states that services are considered to have been provided for an individual with health insurance or third party coverage even though a claim has been "denied due to improper billing, lack of preauthorization, lack of medical necessity, or non-coverage under the third party insurance package." While the quoted sentence may have been inartfully drafted, the overall meaning is clear. The quoted sentence does not indicate that costs related to denials for non-coverage automatically qualify for inclusion in the hospital-specific limit; it simply indicates that certain denied claims cannot be included in the cost limit. When a claim is denied as non-covered, the hospital may then wish to verify that the individual was actually insured, and that the insurance was creditable coverage. Both the statute and the rule clearly indicate that costs of services for individuals who have health insurance (or other source of third party coverage) are not included in calculating the hospital-specific limit, even if insurance claims for that particular service are denied for any reason.

27. The preamble states, "To the extent the Medicaid payment does not fully cover the cost of the inpatient or outpatient hospital services provided, the unreimbursed costs of those services would be counted in calculating that limit." Some hospitals have interpreted this language to mean that any services provided to Medicaid beneficiaries but not reimbursed by Medicaid should be treated as uninsured. Is this interpretation correct?

The interpretation referenced in the question does not accurately reflect the provisions at section 1923(g)(1) of the statute which expressly refers to uncompensated costs of furnishing hospital services to individuals eligible for Medicaid or individuals who have no health insurance or other third party coverage. If an individual is Medicaid eligible on the day they received medically necessary inpatient or outpatient hospital services, then those services (to the extent that they are allowable under the State's plan) would be included in calculating the Medicaid portion of the hospital-specific limit.

28. How should States count costs not otherwise covered for individuals in an IMD (as Medicaid shortfall, uncompensated care costs, or not included) for those individuals with Medicaid ages 22-64 while in an IMD if the individual is also a dual eligible (Medicare)?

For the costs of services provided to those patients between the ages of 22 and 64 who are otherwise eligible for Medicaid, the treatment of the service costs in the hospital-specific limit may vary based on State practice. Many States remove these individuals from eligibility rolls for administrative convenience (and must reinstate them if they are discharged from the IMD); if so, the costs should be reported as uncompensated care for the uninsured. States that do not remove the individuals from the Medicaid eligibility rolls should report the costs as uncompensated care for the Medicaid population. Therefore, the costs of services provided in an IMD to an individual who is 22-64 and who is otherwise Medicaid eligible, can be included either as uninsured uncompensated or Medicaid uncompensated in the UCC, depending on the eligibility status (as determined by the state) of the individual while in the IMD.

For dual eligible patients ages 22-64 old in an IMD, the treatment of costs would be determined by the State Medicaid eligibility policies. In States that do not remove the individual from Medicaid eligibility, these dual eligibles are Medicaid eligible and their uncompensated costs should be included as Medicaid uncompensated costs. In States that remove such individuals from Medicaid eligibility rolls while in an IMD, these individuals would be Medicare only during the IMD stay and therefore considered to have third party coverage (Medicare). Uncompensated care costs would therefore not be allowed in the uninsured uncompensated cost portion.

Hospital Data

29. Because hospitals may not have detailed cost center-specific charge information for uninsured and Medicaid MCO patients for prior years, would it be acceptable to allocate total uninsured or Medicaid MCO charges to specific ancillary cost centers based on the percent to total of Medicaid charges, or, should uninsured or Medicaid MCO costs be disallowed entirely for these hospitals?

We expect that State reports and audits will be based on the best available information in conjunction with guidance from their independent auditors. If audited Medicare cost reports are not available for each hospital, the DSH report and audit may need to be based on Medicare cost reports as filed. We note that hospitals must follow the cost reporting and apportionment process as prescribed by the Medicare 2552-96 cost report process. To the extent that these cost reports do not contain the precise information needed for the DSH calculation, it may be necessary for hospitals to modify their accounting techniques. In those circumstances, for the initial audits, it will be necessary to use other source materials such as audited hospital financial records and other records, and to develop methodologies to determine the necessary

information from such records. We expect States, independent auditors and hospitals to work cooperatively to develop such methodologies.

CMS has developed a General DSH Audit and Reporting Protocol which will be available on the CMS Web site that should assist States and auditors in utilizing information from each source identified above and developing methods to determine uncompensated costs of furnishing hospital services to the Medicaid and uninsured populations. The protocol is available on the CMS Web site at: www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptProtocol.pdf.

30. The regulation requires use of a Medicare hospital cost report to provide data to States and CMS. Some children's hospitals do not care for a large number of Medicare patients and may not file Medicare cost reports or may provide low utilization reports. Is there an alternative reporting tool that children's hospitals could use and still be in compliance with the regulation provisions?

We anticipate that States and auditors will use the best available and most accurate data. The DSH reports and audit will rely on existing financial and cost reporting tools including the Medicare 2552–96 cost report as well as audited hospital financial statements and accounting records in combination with information provided by the States' Medicaid Management Information Systems (MMIS) and the approved Medicaid State plan governing the Medicaid payments made during the audit period. If a hospital (e.g. a children's hospital) does not file or files only a partial Medicare 2552-96 cost report, the State remains responsible for reporting the information which would have otherwise been available on the Medicare 2552-96 from each hospital for Medicaid and uninsured purposes. In order to fulfill the requirements of this section, States may require such hospitals to provide the same data to the State as if they were filing the Medicare 2552-96.

31. When you say "costs of services" or "costs for dual eligibles" do you mean that this term is interchangeable with charges or do you mean just costs?

A. In the regulation, the term "costs" is not interchangeable with the term "charges."

32. As part of the reporting requirements, is the State required to submit a LIUR calculation for every hospital that received a DSH payment or only for the hospitals which are deemed eligible for disproportionate share based on their LIUR?

Under section 1923(b), hospitals may be deemed as disproportionate share hospitals based on either their MIUR or LIUR. We recognize that some hospitals may be so deemed based on both their MIUR and their LIUR. In order to fulfill the requirements of the final rule, States should submit the appropriate calculation for both the LIUR and the MIUR for these hospitals. We believe this is beneficial to both the State and to hospitals. The report must show that each hospital receiving DSH payments meets applicable DSH eligibility requirements. Should a hospital thought to be qualified under the LIUR but is later found not to be, a determination can readily be made about its potential DSH eligibility under the other formula.

Dual Eligibility

33. Would days, costs, and revenues associated with patients that have both Medicaid and private insurance coverage (such as Blue Cross) also be included in the calculation of the

MIUR percentage and the DSH limit in the same way States include days, costs and revenues associated with individuals dually eligible for Medicaid and Medicare?

Days, cost, and revenues associated with patients that are dually eligible for Medicaid and private insurance should be included in the calculation of the Medicaid inpatient utilization rate (MIUR) for the purposes of determining a hospital eligible to receive DSH payments. Section 1923(g)(1) does not contain an exclusion for individuals eligible for Medicaid and also enrolled in private health insurance. Therefore, days, costs, and revenues associated with patients that are eligible for Medicaid and also have private insurance should be included in the calculation of the hospital-specific DSH limit. As Medicaid should be the payer of last resort, hospitals should also offset both Medicaid and third-party revenue associated with the Medicaid eligible day against the costs for that day to determine any uncompensated amount.

34. The regulation states that costs for dual eligibles should be included in uncompensated care costs. Could you please explain further? Under what circumstances should we include Medicare payments?

Section 1923(g) of the Act defines hospital-specific limits on FFP for Medicaid DSH payments. Under the hospital-specific limits, a hospital's DSH payment must not exceed the costs incurred by that hospital in furnishing services during the year to Medicaid and uninsured patients less payments received for those patients. There is no exclusion in section 1923(g)(1) for costs for, and payment made, on behalf of individuals dually eligible for Medicare and Medicaid. Hospitals that include dually-eligible days to determine DSH qualification must also include the costs attributable to dual eligibles when calculating the uncompensated costs of serving Medicaid eligible individuals. Hospitals must also take into account payment made on behalf of the individual, including all Medicare and Medicaid payments made on behalf of dual eligibles. In calculating the Medicare payment for service, the hospital would have to include the Medicare DSH adjustment and any other Medicare payments (including, but not limited to Medicare IME and GME) with respect to that service. This would include payments for Medicare allowable bad debt attributable to dual eligibles.

35. Is it CMS' intention that dual eligibles would include individuals with Medicare for whom Medicaid pays only Medicare deductibles, coinsurance, or Medicare Part A or B premiums?

For the purposes of the DSH audits and reporting requirements, dual eligibles include all individuals with Medicare who also are eligible for some form of Medicaid benefit. This includes those individuals for whom Medicaid pays only Medicare deductibles, coinsurance, or Medicare Part A or B premiums.

36. Medicare DSH allows hospitals to claim additional Medicaid days beyond the paid days for patients with commercial insurance through their employer and Medicaid. Would these patients be included in Medicaid DSH since they are Medicaid eligible?

The Medicare DSH program and the Medicaid DSH program are separate programs authorized by different sections of the statute and with different purposes and goals. If the patients are Medicaid eligible, then costs and revenues associated with inpatient and/or outpatient services furnished to them must be included in the hospital-specific limit calculation. Revenues required to be offset against a hospital's DSH limit would include any amounts received by the hospital by or on behalf of the Medicaid eligible individuals (for any days those individuals remain Medicaid eligible) during the Medicaid State plan rate year under audit (except payments from State or local programs based on indigency).

ARRA

37. How is the DSH audit and reporting rule affected by section 5002 of the American Recovery and Reinvestment Act of 2009 (ARRA)?

DSH payment adjustments made using the ARRA increased state allotments are subject to DSH audit and reporting requirements. ARRA provided additional potential fiscal relief to States by increasing most States' Federal fiscal year (FFY) 2009 and 2010 Medicaid DSH allotments by 2.5 percent. Specifically, section 5002 of ARRA amended section 1923(f)(3) of the Act to provide a temporary increase in state DSH allotments for these fiscal years. Section 5002 of ARRA did not otherwise modify DSH requirements. States are required to follow the same requirements for payment adjustments made under the increased allotment as they would for any other DSH payment adjustments, including DSH reporting and auditing requirements.